Ethnocultural Aspects of Posttraumatic Stress Disorder

Issues, Research, and Clinical Applications

EDITED BY

Anthony J. Marsella

Matthew J. Friedman

Ellen T. Gerrity

Raymond M. Scurfield

AMERICAN PSYCHOLOGICAL ASSOCIATION
WASHINGTON, DC

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TRAUMATIZATION STRESS AMONG ASIANS AND ASIAN AMERICANS

FRANCIS R. ABUEG and KEVIN M. CHUN

The study of traumatic expriences among Asians and Asian Americans is characterized by a comparatively small body of literature. The subset of studies devoted specifically to the examination of posttraumatic stress disorder (PTSD) is very limited. Even the discussion of the application of the construct of PTSD has only recently been broached for such topics as Asian refugees (e.g., Friedman & Jaranson, 1994; Kinzie & Boehlein, 1989; Marsella, Friedman, & Spain, 1993; Mollica, 1994) and Asian war veterans (e.g., Kiang, 1991; Marsella, Chemtob, & Hamada, 1992). Nevertheless, this nascent research literature strongly demonstrates the vast suffering endured by members of various Asian ethnic minority groups. The aim of this chapter is to draw a clear link between ethnic-specific traumatization, psychopathology, and the fledgling literature concerned with PTSD, especially that concerning Southeast Asian refugees settled in North America and Asian American Vietnam veterans.

SOUTHEAST ASIAN REFUGEES

Southeast Asian refugees represent a high-risk population for mental illness because of their extensive exposure to traumatic events and stressors

that typically span four time periods in the refugee experience: (a) premigration, (b) migration, (c) encampment, and (d) postmigration.

Premigration stressors include brutalization and death of family and friends, and loss of property and personal belongings associated with extensive and sustained warfare. Additionally, many Southeast Asians were subjected to government-sponsored intimidation and threats to their livelihood once the Communists gained power in their homelands in Vietnam, Cambodia, and Laos. *Migration stressors* encompass the separation from or deaths of family and relatives while fleeing one's home country under life-threatening conditions. Assaults by border guards while entering neighboring countries were also common occurrences for many refugees.

Encampment stressors are characterized by prolonged detainment in unsafe, overcrowded, and poorly sanitized refugee camps. Many detained refugees also faced uncertainty surrounding their future and the fate of separated family and friends. Finally, *postmigration stressors* involve building a new life in a foreign country, which necessitates the learning of new skills and cultural norms while dealing with the profound loss of loved ones, personal belongings, and even a familiar way of life. Because there is wide variability in the experiences and adjustment levels of Southeast Asians, the traumatic experiences, prevalence rates and high-risk correlates of psychopathology, and special treatment considerations will be presented for each refugee group.

The Vietnamese

The Vietnamese were one of the first Southeast Asian groups to flee their war-torn homelands and journey to the United States (see Mollica, 1994). Premigration stressors for the Vietnamese center around loss of and separation from family and friends, and destruction of personal property during the Vietnam War. Beginning in 1975, first-wave Vietnamese refugees migrated to the United States primarily in family units and represented the educated and professional classes of Vietnam. In contrast, second-wave Vietnamese refugees who fled Vietnam between 1977 and 1980 were mostly of rural and less educated backgrounds (Takaki, 1989). These refugees, most visibly known as the *boat people*, endured severe migration traumas. It is estimated that more than 200,000 of these refugees died at sea as they fled Vietnam on overcrowded and outdated vessels (Lee & Lu, 1989). Furthermore, over 80% of the boats were boarded by pirates who robbed, raped, assaulted, and killed its passengers (e.g., Lee & Lu, 1987; Mollica, 1994).

Those who succeeded in fleeing Vietnam often landed into refugee camps in Thailand, Hong Kong, Indonesia, Malaysia, and the Philippines. In Thailand, Vietnamese refugees faced what was considered the worst

camp conditions and many were detained at Sikhiu, a former jail (Beiser, Turner, & Ganesan, 1989). The life situation of those who remained behind in Vietnam was also precarious at best as many faced the constant threat of indefinite imprisonment in reeducation camps where forced labor, starvation, and torture were commonplace. Past studies indicate that Vietnamese refugees exhibit high levels of psychological and physical distress resulting from their past traumas.

In a recent study (Felsman, Leong, Johnson, & Felsman, 1990), the baseline functioning of Vietnamese youths was examined prior to their exposure to postmigration stressors. Psychological distress among Vietnamese adolescents (13–17 yrs.), unaccompanied minors (13–18 yrs, without adult family members or relatives), and young adults (17.5–20 yrs.) was assessed using the General Health Questionnaire (GHQ), Hopkins Symptom Checklist-25 (HSCL), and the Vietnamese Depression Scale (VDS). Results from this study showed that although high anxiety levels and poor general health were clinically significant across all three groups, the young adult group was especially vulnerable to depression, anxiety, and poor general health.

One of the first studies on the general physical and mental health of first-wave Vietnamese refugees also reported high levels of psychological and physical distress using the Cornell Medical Index (CMI) (Lin, Tazuma, & Masuda, 1979). These researchers noted that 53% of their Phase I participants (data collection in 1975) and 55% of their Phase II sample (data collection in 1976, including both Phase I and new participants) manifested psychological problems. Overall dysfunction, which assessed both physical and psychological problems, was seen in 48% of the Phase I and 56% of the Phase II participants.

Lin, Tazuma, and Masuda (1979) concluded that the similarity of the CMI profiles seen in both phases demonstrates that the mental and physical problems exhibited by these Vietnamese refugees were consistent over time for a 1-year period. Furthermore, they noted that certain segments of the Vietnamese refugee population were significantly at risk for psychological and physical dysfunction. In particular, divorced–widowed female heads of households, individuals over 46 years old, individuals younger than 21 years old, and women between 21 and 45 years exhibited significant levels of dysfunction.

Demographic, premigration, and postmigration predictors of psychological distress were also established in a state-wide community sample of Vietnamese people living in California (Chung & Kagawa-Singer, 1993). In this study, both anxiety and depressive symptoms were associated with demographic variables that included being female, older age, and little or no formal education in one's homeland. Premigration factors predicting

high levels of both anxiety and depression included multiple traumas and fewer years spent in a refugee camp.

The premigration variable—numerous deaths of family members—only predicted anxiety. Postmigration factors predicting both anxiety and depression included a low family income, whereas large family size only predicted depression. Protective factors of psychological well-being among Vietnamese refugees have also been investigated. For example, Tran (1989) found that greater memberships in ethnic social organizations, numerous ethnic confidants, high self-esteem, and high income all significantly contributed to positive psychological well-being for Vietnamese immigrants.

Chun (1991) examined the same statewide sample of Southeast Asians in Chung and Kagawa-Singer's study to investigate correlates of psychosocial dysfunction or impairment in daily living. This variable provides important information beyond knowledge of symptoms alone. In this study, experiential correlates of psychosocial dysfunction included multiple premigration traumas and experiencing few reunions with separated family and relatives. Also, status variables such as being female or unemployed, having poor English-speaking skills, and relocating to a United States residence that is demographically different from one's native residence were correlated with dysfunction among Vietnamese refugees.

Prevalence rates of PTSD among Vietnamese refugees vary across studies. In a study of Southeast Asian patients seen at a specialized refugee clinic, 11% of the Vietnamese sample reportedly suffered from PTSD, a diagnosis that was established using the Diagnostic Interview Schedule (DIS) based on *DSM–III* criteria (Mollica, Wyshak, & Lavelle, 1987). Furthermore, results from this study indicated that multiple traumas was associated with greater susceptibility for PTSD. Kroll et al. (1989) reported that 8.1% of Vietnamese patients in a Southeast Asian psychiatric outpatient population exhibited PTSD. These findings were based on clinical interviews and a 19-item checklist comprising culturally relevant signs of depressive and anxiety symptoms based on *DSM–III* criteria.

This instrument was not cross-validated with other instruments. Women who were widows and increased age until 60 years were associated with increased risk for mental disorders among the general Southeast Asian population in this study. Kinzie et al. (1990) reported that 54% of a sample of Vietnamese psychiatric patients were diagnosed with PTSD using a *DSM–III–R* checklist. Moreover, PTSD was associated with advanced age, female gender, and a diagnosis of depression among this population.

Despite the high levels of psychological and physical distress manifested among the Vietnamese, they are generally better adjusted than other Southeast Asian refugee groups. Across the majority of studies, Vietnamese refugees have exhibited the lowest prevalence rate of PTSD compared with

other Southeast Asian refugees. Chung and Kagawa-Singer (1993) also noted that a Vietnamese sample population was relatively well-adjusted compared with Cambodians and Laotians because community supports were already established upon their arrival to the United States by earlier well-educated and professional first-wave Vietnamese refugees. Along similar lines, past community-based studies have shown that Vietnamese refugees report greater happiness and less depression than Cambodian and Hmong refugees (Rumbaut, 1985) and less alienation than Cambodians, Hmong, and Laotians (Nicassio, 1983).

Cambodians (Khmer)

The Cambodians (Khmer) endured particularly severe premigration traumas beginning in 1975 with the rise of the Pol Pot regime. During this time, Pol Pot lead the Khmer Rouge on a bloody campaign of genocide to establish a Marxist agrarian society and rid the country of any Western influence. Mass executions, forced separations of family members, and confinement to work camps especially targeted at the professional and working classes were subsequently introduced on a national scale. Life in the work camps consisted of hard labor, torture, beatings, starvation, disease, and killings. Upon the Vietnamese invasion of Cambodia in 1979, a quarter of Cambodia's population was decimated and thousands fled to neighboring Thailand, where they were placed in refugee camps.

Cambodian refugees represent a special at-risk group for mental and physical illness because of their far-reaching history of premigration traumas. For instance, significantly higher levels of anxiety and depression have been seen in a nonpatient sample of Cambodians compared with Vietnamese and Vietnamese–Chinese refugees (Foulks, Merkel, Boehlin, 1992). Cambodian refugees also appear to have poorer self-perceptions and see themselves as more different from Americans to a greater extent than do Vietnamese, Laotian, and Hmong refugees (Mollica, 1994; Nicassio, 1983). Similarly, Rumbaut (1985) found that in a Cambodian community sample participants reported more depressive symptoms compared with any other Southeast Asian refugee group.

Chung and Kagawa-Singer (1993) likewise reported that participants from a community sample of Cambodian refugees exhibited the greatest psychological distress, as manifested by depressive and anxiety symptoms, than the Vietnamese and Laotians. In this study, less education and small family size in the United States predicted depression, whereas older age, multiple traumas, increased years spent in a refugee camp, and attendance in English as a Second Language (ESL) classes predicted both anxiety and depressive symptoms. Chung and Kagawa-Singer (1993) stated that this

latter contradictory finding may reflect the ineffectiveness[1] of ESL classes for Cambodians. Correlates of psychosocial dysfunction among Cambodian refugees include older age, multiple traumas, numerous separations from family and relatives, frequent reunions with family and relatives (which may place added strain on limited household resources), and a prolonged stay in refugee camps (Chun, 1991).

The high rates of traumatization reported among Cambodian refugees also appear to be associated with elevated rates of PTSD. Mollica, Wyshak, and Lavelle (1987) reported that 57% of respondents in a Cambodian psychiatric patient sample suffered from PTSD according to *DSM–III* criteria. Moreover, Cambodians experienced the most traumas (M = 16.1 traumas) than the Vietnamese and Hmong/Laotian groups in this study. Of particular concern, Cambodian women who were separated, divorced, or widowed suffered the most traumas and displayed the most serious psychiatric and social impairments of all the patients. Kroll et al. (1989) likewise reported that 22% of Cambodians in a clinic population met *DSM–III* criteria for PTSD, which was the highest percentage of PTSD cases compared to those observed for Vietnamese, Hmong, and Lao refugees. Kinzie et al. (1990) also observed a high rate of PTSD (92%) among their clinic sample of Cambodians using *DSM–III–R* diagnostic criteria.

In a nonpatient sample of Cambodian refugees, a moderate correlation was found between trauma and psychiatric symptoms (Carlson & Rosser-Hogan, 1991). Nonetheless, 86% met modified *DSM–III–R* criteria for PTSD and emotional distress, whereas 96% experienced high levels of dissociation. The authors of this study concluded that the high rate of dissociation in this Cambodian population supports the universality of dissociation as a response to trauma. Kinzie and Boehnlein (1989) also noted that chronic psychotic symptoms may appear following massive psychological trauma among Cambodian refugees.

Past studies have examined Cambodian adolescents and young adults who were traumatized as children, to establish prevalence rates and correlates of PTSD in this population and examine the natural course of PTSD. Realmuto et al. (1992) reported high rates of traumatization among their nonpatient sample of Cambodian adolescents, especially among older youths. The authors stated that older youths may have reported more traumas for several reasons, namely because they were exposed to more traumas that were not applicable to the very young (e.g. forced labor), or simply because they were able to better comprehend or remember traumatic events than their younger counterparts. In any case, 87% of the Cambodian adolescents in this study met *DSM–III* criteria for PTSD, and 37% met the *DSM–III–R* PTSD criteria.

[1]These authors posit that the Cambodians may be suffering from trauma-related cognitive impairments that may contribute to their experience of psychological distress while attending ESL classes.

Realmuto et al. (1992) reasoned that the disparity between these prevalence rates can be attributed to fewer hyperarousal symptoms, which are required in the *DSM–III–R* classification of PTSD, among this population. Clarke, Sack, and Goff (1993) also found that a strong relationship exists between war trauma experienced in childhood and PTSD symptoms experienced in adolescence or young adulthood. Moreover, Cambodian adolescents and young adults reporting PTSD symptoms also reported greater amounts of resettlement stress than those without PTSD symptoms.

In a follow-up study of Cambodian adolescents who were traumatized as children, Kinzie, Sack, Angell, Clarke, and Ben (1989) found that 48% of their sample satisfied *DSM–III–R* criteria for PTSD. This finding was remarkable considering that over 10 years had elapsed since most of the children were traumatized. Kinzie et al., (1989) concluded that this demonstrated that PTSD was relatively stable and persistent over time. Nevertheless, they also mentioned that the Cambodian adolescents seemed to be functioning well in social, work, and family environments despite their high rates of PTSD.

Sack et al. (1993) examined the same population in Kinzie et al's (1989) study to chart the natural course of PTSD from adolescence to young adulthood. Results from this study indicated that 38% of the overall population exhibited a *DSM–III–R* diagnosis of PTSD. The authors stated that although PTSD persists, its symptoms become less intense and frequent over time. Furthermore, the overall functioning of these Cambodian young adults continued to be impressive; they were free of conduct problems, drug and alcohol abuse, and psychological breakdowns.

It is interesting to note that many Cambodians, with the exception of Cambodian women without spouses, are able to function in their social and occupational milieus despite their high rates of psychological and physical distress (Mollica, Wyshak, & Lavelle, 1987). This may be partly attributed to their general outlook on life and Buddhist beliefs. For example, Rumbaut (1985) noted that the Cambodians in a community sample of Southeast Asian refugees reported the most life satisfaction despite their significantly high levels of depressive symptoms and low self-reports of happiness.

Rumbaut (1985) credits this finding to an interaction between the extensive history of premigration traumas among many Cambodians and cultural appraisals of their life situation that are embedded in Buddhist values. In this case, postmigration stressors may be viewed as minor strains when compared with the severe traumas incurred in Cambodia. Furthermore, as will be discussed later in this chapter, many Cambodians frame their traumatic experiences within their Buddhist beliefs. For many Cambodians, life experiences are thus regarded as meaningful occurrences of fate or *kharma* which, from this spiritual perspective, may then contribute to positive adjustment to past traumas.

Laotians

Beginning with the Geneva Accords in 1954, civil discord erupted in Laos as the North Vietnamese-backed Pathet Lao fought the American-supported Royal Lao government for control of Laos, which had then gained independence from France (Takaki, 1989). As the Pathet Lao seized control of Laos in 1979 with the withdrawal of American troops from Southeast Asia, they embarked upon a massive campaign of retribution against former supporters of the Royal Lao government. During this time, thousands of Laotians of diverse social, educational, and economic backgrounds escaped to the adjacent country of Thailand where almost all were detained in refugee camps.

In general, the psychological and physical functioning of the overall Laotian refugee population was somewhat better than or equal to the functioning of other Southeast Asian refugee groups. Nicassio (1983) found that Laotians maintained the best self-perceptions compared with Vietnamese, Cambodian, and Hmong refugees. Furthermore, Laotians did not view themselves as highly different from Americans. Still, many Laotians have endured traumas that have contributed to mental and physical distress.

Chung and Kagawa-Singer (1993) established demographic, premigration, and postmigration predictors of psychological distress among a community sample of Laotian refugees. These researchers found that Laotian women were at higher risk for depression and anxiety than their male counterparts. Additionally, individuals who resided in the United States for a lengthy period were at risk for depression. The premigration variable—numerous traumatic events—predicted both depression and anxiety. Postmigration predictors of depression and anxiety include unemployment and receipt of public assistance. Finally, high family income predicted depression.

Chun (1991) found that the experiential factors—multiple premigration traumas, and few reunions with family and relatives—were correlates of psychosocial dysfunction among Laotian refugees. Status correlates of dysfunction among this group included being female, unemployment, poor English-speaking proficiency, and relocating to a United States residence demographically different from one's native residence.

Kroll et al. (1989) reported that 19.7% of their Laotian patients suffered from PTSD based on *DSM-III* criteria. Kinzie et al. (1990) reported a much higher prevalence rate of PTSD (68%) for a clinic sample of Laotian refugees. These researchers also stated that female and older Laotians were most susceptible for developing PTSD. Finally, Mollica et al. (1987) reported the highest prevalence rate of PTSD at 92% for a patient sample of Hmong/Laotian refugees. This latter finding, however, may be artificially inflated by combining traditionally highly traumatized Hmong refugees with the Laotian refugee sample (see also Mollica, 1994).

Hmong and Mien

Both the Hmong and Mien cultures are rooted in tribal, agrarian, and preliterate societies located in the mountainous regions of Laos and other Southeast Asian countries. The Hmong culture did not possess a written language until American and French missionaries developed one in the mid-1950's (Sherman, 1988). The majority of Hmong withstood premigration warfare during their tenure as CIA-sponsored soldiers whose mission was to combat Pathet Lao Communist guerrillas in the early 1960's (Cerhan, 1990). However, the Hmong became targets of deadly recriminations as the Royal Lao government fell to the Pathet Lao in 1979. Many Hmong were then forced to flee their highland homes and cross into Thailand under perilous circumstances and constant pursuit by Pathet Lao militia men.

Similar to the Hmong, the Mien's education and sociocultural tradition were transmitted orally until they formed a written language in 1982 (Moore & Boehnlein, 1991). The geographical location of the Mien's homeland also placed them in the middle of constant but "unofficial" warfare during the Vietnam War until their mass exodus into Thailand. Relatively little research has been conducted with the Mien in comparison with other Southeast Asian refugees. However, the few studies that exist show marked psychological impairment resulting from extensive premigration trauma and significant postmigration stressors.

Both the Hmong and Mien exhibit severe levels of psychological distress and impaired psychosocial functioning. Rumbaut (1985) found that the Hmong reported the least happiness and life satisfaction and the second most depression in his Southeast Asian community sample. Nicassio (1983) similarly reported that the Hmong exhibited much more alienation than other Southeast Asian refugees. Postmigration stressors may be particularly burdensome for the Hmong and Mien given their sociocultural backgrounds and lack of contact with Western technology and cultural norms. Westermeyer (1989) found that failure to acculturate may exacerbate and contribute to paranoid symptoms among Hmong refugees. Specifically, those who had more intense contacts within the Hmong community and more affiliation with Hmong culture exhibited more paranoid symptoms compared with their more Western-acculturated peers.

Westermeyer (1988) conducted a prevalence study to establish the rates and types of *DSM–III* diagnosis among a community sample of Hmong refugees. Results from this study showed that the majority of Hmong refugees (31%) suffered from adjustment disorder. However, none of the refugees were seeking treatment and half were able to function in their families and occupations despite the chronic nature of their symptoms. Westermeyer thus proposed that these refugees were not suffering

from a psychological disorder per se, but rather from "refugee adjustment syndrome" or "refugee acculturation phenomenon."

Still, it appears that certain symptoms may subside over time. For instance, Westermeyer, Neider, & Callies (1989) found that depression, somatization, phobic anxiety, and self-esteem improved over time and with acculturation. However, anxiety, hostility, and paranoid ideations improved the least. Additionally, strong traditional ties, marital problems, and self-reported medical problems were associated with greater psychological distress, whereas older age was related to higher levels of depression. Chun (1991) also found that multiple premigration traumas and poor English proficiency placed Hmong refugees at risk for psychosocial dysfunction.

Both Hmong and Mien refugees traditionally exhibit some of the highest levels of PTSD. For instance, Mollica et al. (1987) reported that 92% of a sample of Hmong and Laotian patients suffered from a *DSM–III* diagnosis of PTSD. Similarly, Kinzie et al. (1990) found that 93% of a clinic population of Hmong refugees manifested PTSD, the highest rate of PTSD among all Southeast Asian groups. Lastly, Kroll et al. (1989) showed that 11.8% of the Hmong refugees seen in their clinic were PTSD sufferers.

General Conclusions for Southeast Asian Refugee Populations

In sum, there are only a few studies that have actually looked at the prevalence rate of PTSD among Southeast Asian refugees using valid instruments and diagnostic criteria. Also, past findings are often quite variable across studies partly because of differences in sample composition (e.g. patient vs. nonpatient samples) and diagnostic criteria (e.g. *DSM–III* vs. *DSM–III–R* PTSD criteria). Nonetheless, the reported prevalence rates of PTSD for Southeast Asian refugees are remarkably elevated because of nature and extent of their traumatization. Furthermore, these traumatized Asians manifest clinically significant levels of general anxiety and depressive symptoms.

Generally speaking, the Cambodians (Khmer), Hmong, and Mien refugees represent the three most traumatized groups, with the majority arriving within the last decade. Therefore, the immediate concerns of these refugees may center around their premigration traumas. In contrast, Vietnamese refugees have generally been here the longest, so postmigration stressors such as English speaking difficulties and unemployment may be their primary concern. Unfortunately, research on Lao refugees is lacking. Nonetheless, it appears that Lao refugees fall somewhere in the middle of Southeast Asian groups in regards to trauma exposure and overall adjustment levels. According to Gong-Guy (1987), 17% of the Lao sample population reported one or more premigration traumatic events. The percentage of traumatization among other groups is as follows: Cambodians (43%), Hmong (17%), and Vietnamese (14%).

ASIAN AMERICAN VIETNAM VETERANS

A handful of single-case studies and small-sample diagnostic investigations have directly examined the psychological effects of the Vietnam war on veterans of Asian American descent. Initial observations pointed toward some important consistencies among these ethnic minority veterans. Fighting an unpopular war in Southeast Asia during a period of great racial conflict provided the context for unique stressors and psychological consequences for these soldiers.

For example, it has been repeatedly observed that these American soldiers were subjected to racism typically reserved for the enemy, such as being called names such as "gook" and "dink" (e.g., Hamada, Chemtob, Sautner, & Sato, 1988; Marsella, Chemtob, & Hamada, 1990). Loo (in press) identified a number of other race-related stressors and cited a numerous anecdotal accounts: being mistaken for the Vietnamese on the battlefield, race-related physical assault or injury, unintended death or grief, near-death experiences, and nonverbal communications of prejudice.

The bicultural identification of many Asian American Vietnam veterans posed another set of stressors before, during, and after the war. One Japanese American patient described this problem to us as the "banana syndrome: being white on the inside and yellow on the outside" (Abueg & Gusman, 1991). To reaffirm his allegiance with his unit, his fellow soldiers, and his country, this patient would exaggerate his American identity. His Southern drawl would become more pronounced, and he became louder and more aggressive and would use racial epithets for the Vietnamese. These behaviors caused great internal conflict: guilt, shame, and a sense of betrayal of people who reminded him so much of his own family.

Chun and Abueg (1989) conceptualized similar conflicts of a Filipino American Vietnam veteran in a triadic fashion: the intersection among peer norms, parental norms, and cultural norms. Depending on the context (being in war or stateside) and salience of social influences (being close to family, friends; practicing traditions of Filipino culture), the axis of this veteran's identity was in a constant state of flux. Most disruptive to establishing some sense of a "centered self" was the fact that profound traumatic conditioning and PTSD had inhibited successful adaptation regardless of ethnic identity. It was hypothesized that the bicultural identity of this Filipino American exacerbated his sense of instability.

Matsuoka and Hamada (1991) made an important contribution to this literature in studying the variation in the expression of PTSD in Asian American Vietnam veterans across three subgroups: Japanese American, Chinese American, and Native Hawaiian. A fourth group comprised Koreans, Filipinos, and Samoans, each of which had a sample size too small to independently study. The first set of findings confirmed a high degree of ethnic identification with the enemy across a sizable proportion of the 44

veterans in the sample. Feelings of estrangement from fellow American soldiers were also commonly reported.

With regard to rates of PTSD, wide variation across subgroups was found (Matsuoka & Hamada, 1991): no Japanese Americans, 13% of Chinese Americans, 29% of Native Hawaiians, and 40% of the other "mixed" group cited earlier had PTSD diagnoses. Although the authors acknowledged the sampling limitations of their study, they speculated that these findings at least point toward more careful study of predisposing economic and social factors that may place certain groups at psychological risk for traumatization.

It is noteworthy that a major study of prevalence rates among Native Hawaiian and Japanese American Vietnam War veterans is currently in progress in Hawaii under the auspices of the National Center for PTSD of the Department of Veterans Affairs. This study is using methodologies similar to those used in the National Vietnam Veterans Research Study (NVVRS) (see chapter 16 by Schlenger & Fairbank in this volume). The results of the Hawaii Study will provide substantive research data on PTSD rates and expressive patterns for these two groups.

CULTURE-SPECIFIC CONCEPTUALIZATIONS OF TRAUMA TREATMENT

The power of the mental health's professional's conceptualization of PTSD (e.g., Friedman & Jaranson, 1994; Friedman & Marsella, this volume) is that the trauma becomes a centerpiece or touchstone upon which treatment can be based. The findings we have summarized in this chapter suggest that the traumatic experience is not homogeneous even within a specific region like Southeast Asia. Instead of simply paying lip service to the notion of cultural sensitivity (Sue & Sue, 1990), we suggest that the clinician must have a fine-grained understanding of the base rates of traumatization, by specific ethnic subgroups.

For those clinicians experienced with trauma, this may appear at face to be a superfluous or redundant recommendation. However, we believe this point needs particular attention because of the typically unavoidable cultural rifts between patient and therapist, subject and scientist. Hence, specific knowledge must include, for example, how premigration traumas varied between Cambodians and Vietnamese. Understanding these finer variations will undoubtedly have an impact on the empathic quality of interviewer questions; moreover, this knowledge may lead to creative interventions yet to be discussed in this literature. For example, Western therapists can begin to actively incorporate Buddhist principles into their practice for ethnic subgroups who adhere to such beliefs (Canda & Phaobtong, 1992). Creative integration of knowledge about subtle variations

across and within these various cultures and subcultures will likely have direct impact upon patient disclosure and help-seeking, especially about experiences often so horrific and unspeakable. Many developmental (Loo, 1993) and constructivist (Gusman et al., this volume) approaches have begun to articulate such an integration for clinical work.

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